

NQF 0013: Blood Pressure Management

Clinical Quality Measure Quick Reference Guide and Technical Supplement

Provided By:

The National Learning Consortium (NLC)

Developed By:

Health Information Technology Research Center (HITRC)

The material in this document was developed by Regional Extension Center staff in the performance of technical support and EHR implementation. The information in this document is not intended to serve as legal advice nor should it substitute for legal counsel. Users are encouraged to seek additional detailed technical guidance to supplement the information contained within. The REC staff developed these materials based on the technology and law that were in place at the time this document was developed. Therefore, advances in technology and/or changes to the law subsequent to that date may not have been incorporated into this material.

NATIONAL LEARNING CONSORTIUM

The National Learning Consortium (NLC) is a virtual and evolving body of knowledge and tools designed to support healthcare providers and health IT professionals working towards the implementation, adoption and meaningful use of certified EHR systems.

The NLC represents the collective EHR implementation experiences and knowledge gained directly from the field of ONC's outreach programs ([REC](#), [Beacon](#), [State HIE](#)) and through the [Health Information Technology Research Center \(HITRC\)](#) Communities of Practice (CoPs).

The following resource is an example of a tool used in the field today that is recommended by "boots-on-the-ground" professionals for use by others who have made the commitment to implement or upgrade to certified EHR systems.

DESCRIPTION

The Clinical Quality Measure (CQM) quick reference guides provide a summary of key information for CQMs and are intended to be shared with clinical staff using an electronic health record (EHR). The first two sections may be distributed as stand-alone references.

The first section, *Quick Facts*, comes from the CQM e-specifications and is intended to provide an overview of the measure. This section provides information on the measure definition, whether the measure is a core, alternate core, or menu set measure, whether it is related to other measures by common data elements, and what data goes into a numerator, denominator, and exclusions or exceptions.

The second section, *Key Clinical Activities* and *Planning Your EHR Documentation*, is intended to be a space to plan EHR documentation. It provides a "to-do list" of clinical and documentation activities for the measure and lists each data element that is required to calculate the numerator, denominator, and exceptions or exclusions. Providers can use this space to assign individuals or roles to tasks in the to-do list.

The third section, *Technical Supplement*, provides clarifications regarding what "counts" toward this measure. First, it provides English "translations" of the numeric SNOMED-CT, HL7, ICD, and CPT codes that may be used in this measure. Second, it includes clarifications on what constitutes a numerator "hit" or a denominator exclusion based on questions that have arisen during technical assistance calls.

To access the official electronic specifications, visit the CMS Electronic Specifications page <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html> and locate the "EP Measure Specifications" zip file, which contains electronic specifications for all 44 Stage 1 Meaningful Use clinical quality measures.

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NQF 0013: Blood Pressure Management

Percentage of patient visits for patients aged 18 years and older with an active diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.

Quick Facts	
Type of measure: core, alternate core, or menu?	<ul style="list-style-type: none"> Core measure
Related to other measures?	<ul style="list-style-type: none"> Some of the information entered for this clinical quality measure also can be used for calculations in the following measures: <ul style="list-style-type: none"> Controlling High Blood Pressure (NQF 0018) Ischemic Vascular Disease (IVD): Blood Pressure Management (NQF 0073) Diabetes: Blood Pressure Management (NQF 0061)
Data required to identify the <u>denominator</u> (total cases eligible to be counted in measure)	<ul style="list-style-type: none"> Age Encounter codes¹ Diagnosis of hypertension²
Data required to identify the <u>exceptions or exclusions</u>	<ul style="list-style-type: none"> None
Data required to identify the <u>numerator</u> (cases in which the process or outcome being measure occurred)	<ul style="list-style-type: none"> Systolic blood pressure (value entered as structured data)³ Diastolic blood pressure (value entered as structured data)³

Note: This document is meant to supplement and not replace the official electronic specifications for the measure. To access the official specifications, please visit: <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/ElectronicSpecifications.html>

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
1. Confirm the patient's date of birth	<ul style="list-style-type: none"> Ensures only patients who are 18 years and over at the start of the measurement period are included in the denominator 	<ul style="list-style-type: none"> Date of birth 	
2. Record the date and type of visit	<ul style="list-style-type: none"> Ensures only appropriate visits are captured in the denominator⁴. For this measure, two or more encounters are required within the measurement period. 	<ul style="list-style-type: none"> Date of visit Code for an outpatient encounter or nursing facility encounter 	

¹ This data element(s) must be documented during the measurement period

² This data element(s) must be documented prior to or during the measurement period

³ This data element(s) must be documented during the encounter

⁴ See Technical Supplement for denominator inclusion details (encounter types): pp. TS-2

Key Clinical Activities		Planning Your EHR Documentation	
To-Do List	Why Needed?	Data Elements Needed	Responsible Person or Role
3. Ascertain whether the patient has active hypertension. If so, record the diagnosis.	<ul style="list-style-type: none"> • Captures the correct patient population in the denominator. 	<ul style="list-style-type: none"> • Diagnosis code for hypertension 	
4. Use your EHR to record both the systolic and diastolic blood pressure.	<ul style="list-style-type: none"> • Captures the blood pressure measurement activity in your EHR for the numerator. 	<ul style="list-style-type: none"> • Systolic blood pressure value⁵ • Diastolic blood pressure value⁵ 	

⁵ See the Technical Supplement for numerator inclusion details (blood pressure measurement): [pp. TS-2](#)

Technical Supplement

The following pages list the technical definitions of the codes that could be included in the calculation of this measure. Use these lists as needed to confirm that your clinical documentation includes item(s) that are on this list, where appropriate, to ensure accurate calculation of your quality measure denominator and numerator.

DENOMINATOR INCLUSION CRITERIA

What constitutes a nursing facility encounter? (CPT codes)

- Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.

What constitutes an outpatient encounter? (CPT codes)

- Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.
- Office consultation for a new or established patient, which requires these 3 key components: history, an examination, and medical decision making.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Domiciliary or rest home visit for the evaluation and management of a new patient, which requires at least 2 of these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of a new patient, which requires these 3 key components: a history, an examination, and medical decision making.
- Home visit for the evaluation and management of an established patient, which requires 2 of these 3 key components: a history, an examination, and medical decision making.

NUMERATOR INCLUSION CRITERIA

What constitutes systolic blood pressure measurement activity? (SNOMED-CT codes)

- Normal systolic arterial pressure (finding)
- On examination - Systolic BP reading (finding)
- Non-invasive systolic arterial pressure (observable entity)
- Invasive systolic arterial pressure (observable entity)
- Systolic blood pressure (observable entity)
- Minimum systolic blood pressure (observable entity)
- Maximum systolic blood pressure (observable entity)
- Average systolic blood pressure (observable entity)
- Minimum day interval systolic blood pressure (observable entity)
- Minimum night interval systolic blood pressure (observable entity)
- Maximum night interval systolic blood pressure (observable entity)
- Maximum day interval systolic blood pressure (observable entity)
- Average night interval systolic blood pressure (observable entity)
- Average day interval systolic blood pressure (observable entity)
- Minimum 24 hour systolic blood pressure (observable entity)
- Maximum 24 hour systolic blood pressure (observable entity)
- Average 24 hour systolic blood pressure (observable entity)
- 24 hour systolic blood pressure (observable entity)

What constitutes systolic blood pressure measurement activity? (SNOMED-CT codes)

- Target systolic blood pressure (observable entity)
- Systolic blood pressure on admission (observable entity)
- Standing systolic blood pressure (observable entity)
- Sitting systolic blood pressure (observable entity)
- Lying systolic blood pressure (observable entity)
- Systolic arterial pressure (observable entity)
- Decreased systolic arterial pressure (finding)

What constitutes diastolic blood pressure measurement activity? (SNOMED-CT codes)

- On examination - Diastolic blood pressure reading (finding)
- Non-invasive diastolic arterial pressure (observable entity)
- Increased diastolic arterial pressure (observable entity)
- Invasive diastolic arterial pressure (observable entity)
- Diastolic blood pressure (observable entity)
- Minimum diastolic blood pressure (observable entity)
- Maximum diastolic blood pressure (observable entity)
- Average diastolic blood pressure (observable entity)
- Minimum day interval diastolic blood pressure (observable entity)
- Minimum night interval diastolic blood pressure (observable entity)
- Minimum 24 hour diastolic blood pressure (observable entity)
- Maximum night interval diastolic blood pressure (observable entity)
- Maximum day interval diastolic blood pressure (observable entity)
- Maximum 24 hour diastolic blood pressure (observable entity)
- Average night interval diastolic blood pressure (observable entity)
- Average day interval diastolic blood pressure (observable entity)
- Average 24 hour diastolic blood pressure (observable entity)
- 24 hour diastolic blood pressure (observable entity)
- Target diastolic blood pressure (observable entity)
- Standing diastolic blood pressure (observable entity)
- Sitting diastolic blood pressure (observable entity)
- Lying diastolic blood pressure (observable entity)
- Decreased diastolic arterial pressure (finding)
- Normal diastolic arterial pressure (finding)

TYPES OF CODES REQUIRED FROM YOUR EHR FOR CALCULATING THIS CLINICAL QUALITY MEASURE

NQF0013	CPT	CPT Modifier	CVX	Grouping	HCPCS	HL7	ICD-9*	ICD-10	LOINC	RxNorm	SNOMED*
Numerator ¹											×
Denominator ²	×					×	×	×			×
Exceptions or exclusions											

- Codes with an asterisk (*) are required from certified EHRs.
- ¹ To identify the numerator in this CQM, a SNOMED code is required.
- ² To identify the denominator in this CQM, the following standard code lists are required: CPT, HL7 and a specified code from ICD-9, ICD-10 or SNOMED.

Abbreviation	Long Name	Definition/Description
CPT	Current Procedural Terminology	The CPT (Current Procedural Terminology) is produced by the American Medical Association (AMA). CPT codes are used to report medical procedures and services. (Source: CDC)
CVX	Codes for Vaccine Administered	This vocabulary provides terminology for Vaccine Administered. The vocabulary is defined in Health Level Seven (HL7) Version 2.5.1. (Source: USHIK)
HCPCS	Healthcare Common Procedure Coding System	Level I of the HCPCS is comprised of CPT (Current Procedural Terminology), a numeric coding system maintained by the American Medical Association (AMA). Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician's office. (Source: CMS)
HL7	Health Level Seven	HL7 is an accredited ANSI standard organization that produces the HL7 messaging standard. It is the accepted messaging standard for communicating clinical data. It is supported by every major medical informatics system vendor in the US. (Source: ASPE)
ICD-9	International Statistical Classification of Diseases and Related Health Problems, 9th revision	The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on the World Health Organization's Ninth Revision, International Classification of Diseases (ICD-9). ICD-9-CM is the official system of assigning codes to diagnoses and procedures associated with hospital utilization in the United States. The ICD-9 is used to code and classify mortality data from death certificates. (Source: CDC)
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th revision	The International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), published by the World Health Organization (WHO), is the foundation of ICD-10-CM. ICD-10 continues to be the classification used in cause-of-death coding in the United States. The ICD-10-CM is comparable with the ICD-10 (Source: CDC)
LOINC	Logical Observation Identifiers Names and Codes	A universal code system for identifying laboratory and clinical observations. (Source: LOINC)

Abbreviation	Long Name	Definition/Description
RxNorm	RxNorm	RxNorm provides normalized names for clinical drugs and links its names to many of the drug vocabularies commonly used in pharmacy management and drug interaction software, including those of First Databank, Micromedex, MediSpan, Gold Standard Alchemy, and Multum. By providing links between these vocabularies, RxNorm can mediate messages between systems not using the same software and vocabulary. (Source: NLM NIH)
SNOMED-CT	Systematic Nomenclature of Medicine - Clinical Terms	SNOMED CT (Systematized Nomenclature of Medicine--Clinical Terms) is a comprehensive clinical terminology, originally created by the College of American Pathologists (CAP) and, as of April 2007, owned, maintained, and distributed by the International Health Terminology Standards Development Organisation (IHTSDO), a not-for-profit association in Denmark. (Source: NLM NIH)

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